

Fig. 1. Patient with overcorrected Müller muscle resection before and after eyelid stretching.

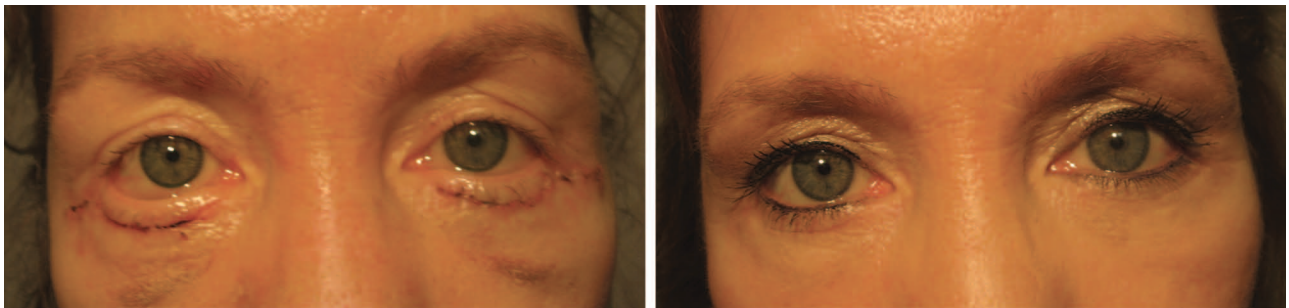


Fig. 2. Patient with cicatricial ectropion and retraction of lower eyelids after a cosmetic blepharoplasty before and after eyelid manipulation.

week postoperatively and the Vicryl sutures are usually removed several weeks postoperatively when the skin wound has healed and the manipulation is usually begun.

I am enclosing several illustrative photographs (Figs. 1 and 2). I hope this additional information is helpful in furthering the understanding of this technique.

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DISCLOSURE

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Revisiting the Role of Columellar Strut Graft in Primary Open Approach Rhinoplasty

Sir:

We have read with great interest the article entitled “Revisiting the Role of Columellar Strut Graft in

Primary Open Approach Rhinoplasty” by Dr. Bitik et al. The authors retrospectively analyzed a series of 100 consecutive primary rhinoplasty cases performed without the use of columellar strut grafts, to determine preoperative, morphed, and actual postoperative changes in nasal tip position.¹

Controlling and maintaining the position and shape of the nasal tip is one of the most important aspects of successful rhinoplasty.² In the article, the authors concluded that preoperative goals regarding nasal tip projection, nasal profile proportions, and columellar integrity could be consistently achieved without using columellar strut grafts.

As several authors have reported, we also believe that, for nasal tip support, the integrity of the natural supporting structures is fundamental and should be reevaluated to avoid postsurgery tip ptosis.^{3,4} In our experience, the presence of a support of septum cartilage is fundamental for maintaining correct tip projection. Ha and Byrd reported the use of an extension graft as an alternative to use of a columellar strut graft⁵; actually, we used septal extension in several cases of traumatic short nose, where there was deficient nasal septal cartilage, and we observed good long-term improvement of nasal tip projection.

In the article, the authors performed all rhinoplasty surgery by closed technique, and this is an advantage when there is the necessity to restore the natural support structures of the nose such as the paramedian and median support ligaments. We believe that it is not easy

to achieve these outcomes in closed rhinoplasty and that, in these cases and in some selected patients, the use of the columellar strut graft could be a valid option. As several authors have reported, fixing the columellar strut graft at the caudal septum guarantees a more long-term and stable outcome, rather than using the columellar strut graft in a floating fashion.^{1,4} In our opinion, the use of the columellar strut graft is an important technique that allows stable tip projection, but one should consider contraindications and alternative options.

The dynamics of nasal tip projection is dependent not only on the tripod concept but also on other natural support elements such as the anterior septal angle. However, the use of a columellar strut graft, especially if fixed at the base of the septum,⁴ could result in stable, long-term nasal tip support with a low complications rate, and it is an important tool in the management of nasal tip.² We think that it could be a valid and very useful option in patients with an underprojected tip and a weak nasal base.

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Reply: Revisiting the Role of Columellar Strut Graft in Primary Open Approach Rhinoplasty

Sir:

My colleagues and I appreciate the response from Dr. Idone et al. regarding our article.¹ We believe that our understanding of nasal tip support mechanisms is very much alike because they have also emphasized the importance of native support structures for nasal tip position and stability. We totally agree with their opinion about the utility of the columellar strut graft in closed rhinoplasty. In the Discussion section of our article, we have already acknowledged that the columellar strut graft works undeniably well in secondary/reconstructive and closed primary rhinoplasties. There is also no question about the efficacy of a long fixed strut in these indications.

Our time is the age of “finesse” in rhinoplasty. Our patients not only demand a good shape and a functional airway but also seek a natural result, and in that sense, a rigid columella is simply unnatural. Although some degree of “nasal tip stiffness” is inevitable after any type of rhinoplasty that involves tip alterations, “columellar rigidity associated with a columellar strut graft” is a distinct entity that has been a matter of concern for our patients in our earlier experience. Therefore, like any other surgical intervention, the columellar strut graft should be used mindfully, for the right indications, rather than habitually.

In their Letter, Dr. Idone et al. mention fixing the columellar strut graft to “the caudal septum.” The classic point of fixation for a long columellar strut graft is the anterior nasal spine. Fixing the strut graft to the caudal septum in a side-to-side fashion transforms it into a septal extension graft. Fixing the columellar strut/medial crura compound to the caudal septum in an end-to-end fashion would better be defined as a “septocolumellar suture.” These types of caudal septal fixation techniques should be differentiated from Rohrich type 4 long and fixed columellar strut grafts.²

Currently, I do not hesitate to use a short columellar strut in primary open approach rhinoplasty cases where (1) the medial crura are found inherently weak or asymmetric and/or (2) a wider columella is cosmetically desirable. These cases constitute approximately 5 to 10 percent of our primary open approach rhinoplasties.

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